GA DEPT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE

Additional Location Application Instructions

A. Applicant: *Use this application if you are an individual practitioner with an existing Georgia Medicaid provider number*.

1. If the applicant is an individual practitioner, give the applicant's name. The practice name is optional. If you complete section 1, you will need to skip sections 2a and 2b.

2a. If the applicant is not an individual practitioner, give the business name. The "legal business name" is required. The "doing business as" name is optional. If you complete section 2, you should not have completed section 1. Facility Type valid values:

0	Government	1	Non-profit or Religious	2	Sole Proprietorship
3	Investor Owned	4	Public	5	Private - For Profit
6	Private - Not for Profit	8	Not Applicable	9	Other

3. This "Office Manager" information is required in order to obtain a web portal user id for members of your office staff.

B. Address Information:

1. The Office (Physical) Address is required for all providers. This is the street address from where you intend to provide services to Medicaid and/or PeachCare for Kids members. **Post office boxes are not allowed**.

2. The Mailing Address is optional. Use this field if you receive postal mail at an address other than the address provided above. Post office boxes are allowed.

3. The Pay-to Address is the address where you would like remittance advices, and other payment information, sent. This address is obtained from the W-9 form or the established Payee Provider Number.

C. Detailed Information:

1. This number is assigned by the Internal Revenue Service and should match the number provided on the W-9.

2. Enter the National Provider Identification number (if assigned)

3. Provide Medicare participation information. Your Medicare information **must** be on file if you wish to receive Medicare crossover payments.

4. Indicate any languages that are spoken at the practice location. Place a check in the box next to the primary language.

BA	Bangla	CC	Cambodian/Campuchean	CH	Chinese (Mandarin)
CZ	Czech	EN	English	FA	Farsi
FP	Filipino	FR	French	GE	German
HI	Hindi	IN	Indian	IT	Italian
JA	Japanese	KO	Korean	LA	Laotian
NA	Navajo	PO	Portuguese	RU	Russian
SA	Slavic	SL	American Sign Language	SP	Spanish
SW	Swahili	TA	Taiwanese	TU	Turkish
VN	Vietnamese	ZZ	Other		

5. Special needs valid values:

AD	Attention Disorders	AL	Allergic Disease	AR	Arthritis
AS	Asthma	CD	Cardiology	CR	Counseling Referral
DB	Diabetes	DI	Dialysis	EK	Electrocardiogram
EN	Endoscopy	ES	Emergency Services	FP	Family Planning
GE	Geriatric	GI	Gastro	HI	HIV/AIDS

HM	Holter Monitor	HY	Hypertension	LA	Laboratory
LS	Laser Surgery	MW	Mid-Wifery	NS	Norplant
OB	OB/GYN	OS	Office Surgery	UR	Urology
OX	Office X-Ray	PA	Physical Accessibility	PD	Pediatrics
PF	Pulmonary Function Test	PM	Pain Management	RH	Rheumatology
RT	Respiratory Therapy	SU	Surgery	TE	Telemedicine
TL	Telegu	OT	Other Special Needs		

a. Attach a copy of proof of liability insurance. Required for participation in Durable Medical Equipment (320), Orthotics and Prosthetics/Hearing Services (330), Ambulance Services (370, 371), and Georgia Better Health Care (850).

D. Program Enrollment Information (see instructions for valid code values):

1. Provider Type valid values:

100	Behavioral Health & Social Ser	110	Chiropractors (Medicare Only)
120	Dentist Service Providers	130	Dietary and Nutritional Service
140	Emergency Medical Service Provider	150	Eye and Vision Providers
160	Nursing Services	170	Other Service Providers
180	Pharmacy	200	Physicians / Osteopaths
210	Podiatrists	220	Respiratory, Rehab, & Restoration
230	Speech, Language, & Hearing Se	240	Technologists, & Technicians
250	Agencies	251	Public Health Agencies
260	Ambulatory	270	Hospital Units
280	Hospital	290	Laboratories
300	Managed Care Organizations	310	Nursing Facilities
320	Residential Treatment Facilities	330	Medical Supplier
340	Transportation	360	Nurse Practitioners / Physician
370	Nursing Related Services	380	Home and Community Based Services

2. Practice Type valid values:

C	Corporation	G	Group Practice (Private)	H	Hospital Based Physician
I	Individual Practitioner	L	Public Clinics	M	Health Maintenance Org
T	Teaching Provider	R	Pre-Paid Group Practice Plan	P	Partnership / Professional Assoc
N	Not Applicable	O	Other		

3. Categories of Service valid values:

740	Advanced Nurse Practitioners	820	Licensed Clinical Social Worker - Medicare Only
910	Childbirth Education Program	480	Nurse Midwifery
840	Children's Intervention Services	490	Oral Maxillofacial Surgery
560	Chiropractics - Medicare Only	761	Perinatal Targeted Case Mgt
460	Dental Program – Adult	300	Pharmacies
450	Dental Program - under 21	410	Physical Therapy - Medicare Only
721	Dialysis Services – Professional	430	Physician Services
800	Early Intervention Case Mgmt	431	Physician's Assistant Services
970	GAPP- Case Management	550	Podiatry
971	GAPP – In-Home Private Duty Nursing	730	Pregnancy Related Services
972	GAPP-Medically Fragile Daycare	570	Psychological Services (Psychologists)
371	Emergency Air Ambulance	420	Rehabilitation Therapy – Medicare Only
370	Emergency Ground Ambulance	400	Speech Therapy - Medicare Only
270	Family Planning Services	470	Vision Care
600	Health Check Services		

4. Group Code valid values:

G	Group Owner Only	I	Individual
M	Group Member	O	Group Owner / Member
N	None		

5. Specialty Codes valid values:
   Please see attached list

E. License and Certification Information:

1. Enter professional license information.
2. Certification information may be required based on the Category of Service for which you are applying.

F. Exclusion / Sanction Information:

1-4. Please provide information regarding previous and current exclusions and sanctions.

G. Signature and Contact Information:

1. Please provide contact information for the person who will be able to answer questions regarding this application.

2. Applications for individual practitioners must be signed by the applicant. Facility applications should be signed by the administrator.

Provider Enrollment Application Instructions – D5

Specialty Codes valid values

001	Acupuncture Medicine	002	Addictionologist	003	Administrative Medicine
004	Adolescent Medicine	005	Adult Day Health Care	006	Aerospace Medicine
008	Allergy	009	Allergy and Immunology	010	Alternative Living Services
011	Ambulance Company, Licensed	012	Ambulance Company, non-license	013	Ambulatory Surgery
014	Anatomic Pathology	015	Anesthesiology	016	Anesthesiology Critical Care M
017	Athletic Trainer, Certified	018	Audiologist	019	Audiology Services
020	Aviation Medicine	021	Behavioral Mgmt Svcs, Pediatri	022	Birthing Center
024	Broncho-Esophogology	025	Cardiac Electrophysiology	027	Cardiology
028	Cardiovascular Disease	029	Cardiovascular Surgery	030	Case Management
031	Cert Registered Nurse Anesthet	033	Child Birth Education	034	Chiropractics Examiner
038	Clinical Pharmacology	039	Colon and Rectal Surgery	040	Community Health Centers
041	Counselor, Professional	042	Critical Care Medicine	043	Cytopathology
044	Day Habilitation	045	Day Treatment Services	046	Dedicated Case Management
047	Dentistry, General Practice	048	Dermatology	049	Dermatopathology
050	Dermatology Immunology / Diag	051	Diabetes	054	Diagnostic Radiology
055	Dialysis, Professional	056	Dialysis, Technical	057	Disproportionate Share Hospita
058	Durable Medical Equipment Supp	059	Ear, Nose, Throat	060	Early Intervention, Agency
061	Early Intervention, Individual	062	Emergency Medicine	063	Emergency Treatment Facility
064	Emergency Response System	065	Endocrinology	066	Endodontics
067	Environmental Modifications	069	Eye, Ear Nose, Throat	071	Family Planning
072	Family Practice	073	Family Practice Geriatric Medi	074	Gastroenterology
075	General Practice	076	General Surgery	077	Geriatrics
078	Geriatric Psychiatry	079	Clinic or other Group Practice	080	Gynecology
081	Hand Surgery	082	Health Check, Health Dept	083	Health Check, Other
084	Hematology	085	Hematology/Oncology	086	Home Delivered Meals
087	Home Delivered Services	088	Home Health Agency	090	Hospice Facility
091	Hospital, Regular General	092	Hospital, Military	093	Hospital, Psychiatric, Freesta
094	Hospital, Specialized Long Ter	095	Hyperbaric Facility, Freestand	097	Immunology
098	Immunopathology	099	Independent Lab	100	Infectious Diseases
102	Internal Medicine	103	Internal Medicine Critical Car	105	Laryngology
107	Licensed Clinical Social Worke	108	Licensed Dietician	111	Maternal and Fetal Medicine
112	Maxillo-Facial Surgery	115	Medical Toxicology	117	Migrant Health
118	Molecular Genetics, Clinical	119	Neonatology	120	Neonat-Perinatal Medicine
121	Neopathology	122	Neoplastic Oncology	123	Nephrology
124	Neurology	125	Neurological Surgery	126	Neuro-Opthalmology
127	Neuropathology	128	Neuropsychology, Clinical	129	Neurophysiology, Clinical
130	Neuroradiology	133	Nuclear Cardiology	134	Nuclear Medicine
135	Nuclear Radiology	136	Nurse Midwife, Contracted	137	Nurse Midwife, Non-Contracted
138	Nurse Practitioner, Adult	139	Nurse Pract, Family Health	140	Nurse Practitioner, General
141	Nurse Practitioner, Geriatric	142	Nurse Practitioner, OB/GYN	143	Nurse Practitioner, Pediatric
144	Nursing Home / Domiciliary Fac	145	Nutrition	146	Obstetrics
147	Obstetrics & Gynecology	148	OB & Gynecology Crit Care	149	Occupational Medicine
151	Occupational Therapy	152	Ocularists	153	Oncology
154	Ophthalmology	155	Optometry	156	Oral Maxillofacial Surgery
157	Oral Surgery	159	Orthodontics	160	Orthodontic Prosthetics, Non A
161	Orthopedic Surgery	162	Orthopedic Hand Surgery	163	Orthotists
164	Osteopathy	165	Otolaryngology	166	Otology, Laryngology, Rhinolog
167	Pain Management	168	Pathology	170	Pediatrics
171	Pediatric Allergy	172	Pediatric Cardiology	173	Pediatric Developmental & Beha
175	Pediatric Emergency Medicine	176	Pediatric Endocrinology	177	Pediatric Gastroenterology
178	Pediatric Hematology-Oncology	179	Pediatric Infectious Disease	180	Pediatric Internal Medicine
181	Pediatric Nephrology	182	Pediatric Neurology	183	Pediatric Neurosurgery
184	Pediatric Pathology	185	Pediatric Pulmonology	186	Pediatric Rheumatology
187	Pediatric Sports and Fitness M	188	Pediatric Surgery	189	Pediatric Ophthalmology
190	Pediatric Orthopedics	191	Pediatric Otol, Laryng, Rhin	192	Pediatric Urology
193	Pedodontics	194	Perinatology	195	Periodontics
196	Periph Vascular Disease	198	Pharmacy	199	Pharmacy Supplies
200	Physical Medicine Rehab	201	Physical Therapist	203	Physician Assistant
204	Physician Assistant, Anesthesi	205	Plastic Surgery	206	Plastic Surgery Hand Surgery
207	Podiatry	208	Practical Nurse, Licensed	211	Preventative Medicine
212	Proctology	213	Professional Nurse	214	Prosthetists
215	Prosthodontics	218	Psychiatric Nurse	219	Psychiatric Social Worker
220	Psychiatry, Board Certified	221	Psychiatry, Child/Adol	222	Psychology
223	Public Health	224	Public Health Dentistry	225	Pulmonary Medicine
227	Radiation Oncology	228	Radiation Therapy	229	Radioisopic Pathology
230	Radioisotopic Pathology	232	Radiology	234	Registered Nurse
239	Rehabilitation Medicine	240	Renal Dialysis Center	241	Reproductive Endocrinology
245	Rheumatology	251	Speech-Language Pathology	252	Speech Therapy
253	Sports Medicine	254	Internal Sports Medicine	256	Surgical Oncology
257	Surgery	258	Surgery, Critical Care	262	Therapeutic Radiology
263	Thoracic Surgery	264	Transplant Surgery	265	Transplant Surgery, Liver

268	Urology	269	Vascular Surgery	273	Medical Supplies
279	Pediatric Plastic Surgery	280	Pediatric Dermatology	281	Pediatric Ear, Nose, Throat
282	Pediatric Interventional Radiology	283	Pediatric Medical Toxicology	284	Pediatric Neurodevelopment
285	Pediatric Rehab Medicine	286	Pediatric Radiology	289	Behavioral Management
290	Interventional Radiology				

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE
Additional Location Application Form

A. Applicant:

1. Current Rendering Provider Number(s):_____

2. Current Payee Provider Number(if available):_____

First M.I. Last Suffix (Jr, III, etc.) Title (MD, RN, etc)

Social Security #: _____ Practitioner's D.O.B.: _____

Practice or Business Name (if applicable):

3. Pharmacies ONLY:

Legal Business Name

"Doing Business As" Name

Does this organization operate other sites, locations or units? □ No; □Yes Where: _____

c. Drug Store Type: □ Proprietary; □ Non-Proprietary d. Pharmacy Class Code: _____

4. Office Manager's Information:

Name

Email Address Social Security Number Date of Birth

B. Address Information:

1. Office (Physical) Address:

Street Address **(P.O. Box Not Acceptable)** Suite No.

City County State Zip Code (+ 4)

(____)_____(____)_____
Office Telephone Number Office Fax Number

(____)_____
After Hours Telephone Number

Office E-mail Address (if available) Office Website Address (if available)

Is this location open 24 hours? □ No; □ Yes Is this location TDD/TTY equipped? □ No; □ Yes

2. Mailing Address (if different from physical address):

_____
Street Address /PO Box Suite No.

_____

_____
City County State Zip Code + 4

(_____)_____(_____)_____
Alternate Telephone Number Alternate Fax Number

_____
Alternate E-mail Address (if available) Alternate Website Address (if available)

3. Pay-to Address: The pay-to address should be placed on the W-9 form.

C. Detailed Information:

1. Federal Employer ID#: _____ 2. NPI#: _____

3. Does this applicant have Medicare certification? *(Please attach a copy of your Medicare certification award letter.)*

_____
Medicare Provider Number Effective Date

_____
Medicare Carrier/Intermediary Name

☐Medicare ONLY *(Check this box if you intend to bill Crossovers only.)*

4. Languages spoken at this location (Please put a check by the primary language)(*see instructions for valid code values*):
❑_____ ❑_____ ❑_____ ❑_____

5. Special Needs (What special needs are accommodated at this provider location?)(*see instructions for valid code values*):

_____ _____ _____ _____ _____

6. Liability Insurance amount: _____
(required for certain programs) (*attach a copy of proof of insurance*)

D. Program Enrollment Information (see instructions for valid code values):

1. Provider Type Code: _____ 2. Practice Type Code: _____

3. Category(ies) of Service: _____ _____ _____ 4. Group Code: _____

5. Specialty Code(s): _____ _____ _____ _____

E. License and Certification Information:

1. License Information for state of practice (Attach a copy):

a. _____
License Number Type Effective Date Expiration Date

b. Do you have public board orders? ☐ No; ☐ Yes If yes, date of the last order: _____

Are you**:** ☐ Board Eligible; ☐ Board Certified Specialty: _____

2. Certification Information (Attach a copy):

Type	Certification Number	Effective Date	Expiration Date

F. Exclusion / Sanction Information:

1. ***Has the applicant ever had any adverse legal actions imposed by Medicare, Medicaid, or any other Federal or State agency or program, or any licensing or certification agency? Attach a copy of any relevant final dispositions.***
   ☐ No; ☐ Yes (If "yes", please attach details)

2. Has any member of your practice ever been placed on prepayment review status by Georgia Medicaid?
   ☐ No; ☐ Yes (If "yes", please attach details)

   Has any member of your practice had a recoupment of over $5,000 in any 18 month period?
   ☐ No; ☐ Yes (If "yes", please attach details)

3. Has any family or household member(s) of the applicant who has ownership or control interest in the applicant ever been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State health care program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?
   ☐ No; ☐ Yes

   If Yes, furnish name and relationship of relative/household member(s) below. Attach additional sheets if necessary.

First	M.I.	Last	Title (if applicable)	Relationship

4. Have you or this facility been involved in malpractice litigation within the last ten (10) years?
   ☐ No; ☐ Yes (If "yes", please attach detailed explanation and disposition of case)

G. Signatures and Contact Information:

1. Contact Person Information

List the contact person in your office who may answer questions regarding this application:

Contact Person _____ Title _____

Mailing Address (if different from enrolling address) _____

_____

Telephone Number _____ Fax Number _____ E-Mail Address (if available) _____

2. Certification and Signature

To the best of my knowledge, the information supplied in this document is true, accurate and complete and is hereby released to the Georgia Department of Community Health, Division of Medical Assistance for the purpose of issuing a Medicaid provider number. I understand that falsification, omission or misrepresentation of any information in this enrollment package will result in a denial of enrollment, the closure of current enrollment, and the denial of future enrollment requests, and may be punishable by criminal, civil or other administrative actions. I understand that my signature certifies that I have read the manuals, Parts I, II, and III (if applicable), for the Category(ies) of Service indicated herein.

_____
Printed Name of Applicant

_____ _____
Signature of Applicant Date